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**EVALUATION OF THE GRANT PROGRAM FOR
RURAL HEALTH CARE TRANSITION
FOURTH SEMI-ANNUAL PROGRESS REPORT**

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Authors:

Valerie Cheh
Katherine Condon
Charles Nagatoshi
Judith Wooldridge

Submitted to:

Health Care Financing Administration
6340 Security Boulevard
Oak Meadows Building, Room 2302
Baltimore, MD 21207

Submitted by:

Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, N.J. 08543-2393
(609) 799-3535

Project Officer:

Kathleen Farrell

Project Director:

Judith Wooldridge



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EXECUTIVE SUMMARY

The Health Care Financing Administration (HCFA) was charged by Congress with implementing a program of Rural Health Care Transition Grants (Omnibus Budget Reconciliation Act of 1987: P.L. 100-203) and expanding the program (Omnibus Budget Reconciliation Act of 1989: P.L. 101-239). The goal of this program is to assist small rural hospitals to increase their long term financial stability and management capacity.

Awards of up to 2 years duration and up to \$50,000 a year per hospital were made on September 15, 1989, to 181 hospitals representing 184 grant awards. Additional awards of up to 3 years and up to \$50,000 a year per hospital were made on September 15, 1990, to 211 hospitals, representing 212 grant awards. Grants were awarded based on technical merit and with the goal of achieving geographic dispersion of the grant funds. Congress appropriated \$8,254,442 to fund the first year of the 1989 grantees and \$16,798,351 to fund the second year of the 1989 grantees and the first year of the 1990 grantees. Congress appropriated an additional \$24,398,000 to fund the third year of the 1989 grantees, the second year of the 1990 grantees, and the first year of the 1991 grantees.

The legislation mandated that the HCFA Administrator report to Congress every 6 months on the progress of the program. This is the fourth 6-month report. This report is based on background reports and monitoring reports submitted by the grantee hospitals covering the period September 15, 1990, through March 31, 1991. The report describes changes in the management and staffing of the 1989 grantees, and their progress after 18 months. Special focus is given to the 1989 grantee hospital consortia projects and hospital closures among the 1989 grantees, planned and unplanned. This report also describes the progress of the 1990 grantees after their first 6 months.

1989 Grantees. Eighteen months after the awards, 169 of the 181 hospitals that received grants are operating their grant projects as planned, while five have completed their projects. Eight hospitals are no longer in the program because of voluntary withdrawal (four hospitals), nonrenewal by HCFA (one hospital), and facility closure (three hospitals).

Slightly under half of the active projects are on or ahead of schedule in all aspects of their projects. Since most projects include several activities, many grantees are further ahead with some activities than others. For example, after 18 months the grantees have made considerable progress completing their construction and renovation activities and converting acute care beds to swing beds. (Six months ago, most construction and

renovation activities were behind schedule). Health professional training and patient education activities are predominantly on schedule.

Hospitals cite the availability of funds (grant and other), cooperation with other providers or government agencies, dedication of the hospital staff, and the project filling a local health care need as keys to success. Conversely, hospitals cite difficulty recruiting health care professionals as a key factor slowing the projects. The consortium projects are progressing very smoothly, with 70 percent of the hospitals involved in these projects reporting that they are on schedule.

Seven of the 1989 grantee hospitals have closed, but four of them used their grants to plan their transition from an acute care institution to another type of health care provider. These hospitals appear to be maintaining access to primary care in their areas.

Hospitals submitting progress reports in time for inclusion in this report had spent most of their 2-year grant award. Of the grant funds that have been spent, 45 percent was spent on personnel, 22 percent on contracts, and 18 percent on capital expenditures. A few grantees have spent less than 50 percent of their award and most of these grantees are behind schedule.

1990 Grantees. In 1990, 502 applications were received from 481 hospitals: 202 fewer applications than in 1989. On September 15, 1990, HCFA awarded 212 grants to 211 hospitals for a total grant funding of \$9,389,649. Six months after the awards, 209 of the 211 hospitals that received grants are operating their grant projects as planned, while two voluntarily withdrew from the program.

The 1990 grantees had a slow start. Six months after receiving their grant awards, 61 percent report that they are behind schedule. As with the 1989 grantees, progress has been slowed by difficulties recruiting health care professionals. Activities that tend to be on or ahead of schedule are patient education, outpatient care development, hospice service development and swing bed conversion. Hospitals attribute successful start up to strong strategic plans, cooperation with other providers or government agencies, and the availability of funds.

Like their 1989 counterparts, the 1990 grantees are spending most of their funds on personnel (35 percent), capital (23 percent) and contracts (19 percent). Over half of the grantees have spent 25 percent or less of their first year award, and 11 percent have spent more than half of their award (comparable to the 1989 grantees at the same stage of their projects).

I. INTRODUCTION

A. LEGISLATIVE HISTORY AND PURPOSE OF THE GRANT PROGRAM

Congressional concerns about the problems of rural hospitals and access to health care for the residents of rural areas led to the enactment of the Grant Program for Rural Health Care Transition. In the legislation, Congress mandated that the Health Care Financing Administration (HCFA) "establish a program of grants to assist eligible small rural hospitals and their communities in the planning and implementation of projects to modify the type and extent of services such hospitals provide in order to adjust for one or more of the following factors:

- (1) Changes in clinical practice patterns
- (2) Changes in service populations
- (3) Declining demand for acute-care inpatient hospital capacity
- (4) Declining ability to provide appropriate staffing for inpatient hospitals
- (5) Increasing demand for ambulatory and emergency services
- (6) Increasing demand for appropriate integration of community health services
- (7) The need for adequate access to emergency care and inpatient care in areas in which a number of underutilized hospital beds are being eliminated."¹

¹Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), Section 4005(e).

The legislation further stipulates that "a grant may not exceed \$50,000 a year and may not exceed a term of two years."² Funds may be spent for any expenses incurred in planning and implementing the project with two exceptions: no part of the grant funds may be expended to retire debt incurred before September 15, 1989;³ and not more than one-third of the grant funds may be used for capital-related costs. The legislation mandated that grantees had to be non-Federal, nonproprietary, short-term, general acute care hospitals with fewer than 100 beds and furthermore they had to be paid as rural hospitals under Medicare's Prospective Payment System to be eligible for the program.

In the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239), Congress modified the Rural Health Care Transition Grant Program in two important ways. First, the maximum grant period was extended from 2 to 3 years. Second, hospitals that use the grant to convert to a rural primary care hospitals are not limited to the one-third capital expenditure maximum.

B. NUMBER AND GRANTEE STATUS

1. 1989 Grantees

The vast majority of the 184 Rural Health Care Transition grants HCFA awarded on September 15, 1989, remain active 18 months later. (See Table I.1.) As of

²Ibid.

³Date of grant award.

TABLE I.1
1989 GRANTEE STATUS

	Time Period				
	At Award 9/15/89	Month 6 3/15/90	Month 12 9/15/90	Month 18 3/15/91	Cumulative 9/15/89 - 3/15/91
Number of Grantees (Hospitals) at Start of Period	184 (181)	182 (179)	181 (178)	172 (170)	184 (181)
Number of Voluntary Terminations in Period	2 ^{a,b} (2)	0	2 ^{d,e} (2)	0 (0)	4 (4)
Number of HCFA Terminations in Period	0	0	1 ^f (1)	0 (0)	1 (1)
Number of Hospitals Ceasing Operating and Terminated in Period	0	1 ^g (1)	1 ^g (1)	1 ^k (1)	3 (3)
Number Completed in Period	0	0	5 ^{h,l} (4) ^j	0 (0)	5 (4)
Number Remaining at End of Period	182 (179)	181 (178)	172 (170)	171 (169)	171 (169)

NOTE: Four hospitals have ceased hospital operations but are still grantees (including one that changed its scope to convert to a primary care clinic).

^aBreckinridge Memorial Hospital, Kentucky

^bArkansas Memorial Hospital, Arkansas

^cSalamanca District Hospital, New York

^dRangely District Hospital, Colorado

^eWilson Memorial Hospital, Texas

^fCalhoun General Hospital, Florida

^gSt. Luke General Hospital, Louisiana

^hChurchill Regional Medical Center, Nevada

Elko General Hospital, Nevada

Mt. Grani General Hospital, Nevada

Nye Regional Medical Ctr., Nevada

ⁱBoone County Community Hospital, Nebraska

^jBoone County Community Hospital completed one of its two grant projects. It continues with the second grant project.

^kCorning Community Hospital, Arkansas

March 15, 1991, 169 hospitals are still working on 171 grant projects. Only one hospital left the grant program in the past 6 months (it ceased hospital operations).

Five of the grant projects were completed. Four grantees were in a single' consortium teleradiology project in Nevada that completed its goals. Boone County Community Hospital in Nebraska successfully completed its service assessment and cost-reduction plans at the end of the first year. This hospital continues with another grant project.

Four of the grantee hospitals voluntarily terminated their grants, two at the time of the award and another two at the end of the first year. Another three facilities, one in each 6-month period, discontinued their grant projects after they could no longer continue to operate as acute care hospitals. In only one instance was it necessary for HCFA to deny continued grant funding because of a hospital's failure to comply with the terms and conditions of the grant.

The footnote to Table I.1 provides information on four facilities that ceased hospital operations but used grant funds to convert to nonacute health care service providers.

2. 1990 Grantees

On September 15, 1990, HCFA awarded 212 grants to 211 hospitals. Of the 211 hospitals, two, Seymour Hospital and Frio Hospital, both located in Texas, voluntarily discontinued their grants (see Table I.2). Seymour Hospital elected not to accept the

TABLE L2
1990 GRANTEE STATUS

	Time Period	
	At Award (9/15/90)	Cumulative (9/15/90 - 3/15/91)
Number of Grantees (Hospitals) at Start of Period	212 (211)	212 (211)
Number of Voluntary Terminations in Period	2 ^{a,b} (2)	2 (2)
Number of HCFA Terminations in Period	0 (0)	0 (0)
Number of Hospitals Ceasing Operations and Terminated in Period	0 (0)	0 (0)
Number Completed in Period	0 (0)	0 (0)
Number Remaining at End of Period	210 (209)	210 (209)

^aSeymour Hospital, Texas

^bFrio Hospital Association, Texas

grant award after concluding that unanticipated administration problems would prevent it from carrying out its grant project. Frio Hospital initially accepted the grant award, only to decline it later without spending any of the funds.

None of the other facilities have reported suspending their hospital operations. Neither has HCFA terminated any grants for noncompliance with the terms and conditions of the grant, nor has any hospital reported completing its grant project during the first 6 months.

II. BACKGROUND ON 1989 GRANTEES

Grant project success depends on a number of factors. One key factor is the size and stability of the hospital's professional staff, which is the subject of the first section of this chapter. The importance of an adequately sized and stable professional staff can scarcely be overstressed. Without an administrator, the hospital does not operate. Without physicians, there are no patients. Without an anesthesiologist or a nurse anesthetist, there is no surgery. Without laboratory technicians, diagnostic capacity is limited. And the list goes on. Rural hospitals can deliver health care services without equipment; they cannot deliver services without health professionals. Section A discusses changes in management and the professional staff and concomitant changes in the number of beds and services available among the 1989 grantees during the first year of the grant program.

While hospitals in consortium projects share the same management and staffing issues as other hospitals, they also face different potential advantages and disadvantages. Alliances have the potential to help members manage resources more effectively. However, there is also the potential for miscommunication and destructive competition within the consortia. The spread of alliances among rural hospitals suggests that alliances are perceived to be effective in helping rural hospitals survive. Section B describes the participation of all the grantees in consortia as well as characteristics of the Rural Health Care Transition grant-funded consortia.

A. CHANGES IN HOSPITAL CHARACTERISTICS AFTER 1 YEAR

1. Management Changes Over First Year

An important factor for the success of the grant projects may be the stability of hospital management. Continuity of a project can be interrupted when the hospital administrator leaves, especially when the hospital administrator is the project director. Even if the hospital administrator is not the project director, a change in administration can adversely affect the project's progress. Sometimes the administrator's departure is unanticipated, requiring appointment of an interim administrator who may be wary of making long-term commitments. (Seven percent of the 1989 grantees were operating under interim administrators at the 1-year mark). Even if an administrative change goes smoothly, it may take a while to explain the project to the new administrator and win his or her support.

Almost one third of the grantee hospitals changed administrators at least once from the time the hospital applied for the grant to the end of the first year of the project (an 18-month period) and one quarter of these hospitals changed hospital administrators at least twice (see Table II.1).¹ This translates to an annualized turnover of administrators in grantee hospitals of one fifth, a little less than the national turnover in hospital

¹Section A is based on self-reported data collected from 166 grantees that received grants in 1989 and were still operating as hospitals at the end of the first year. Thus, this analysis of hospital characteristics excludes the four grantees that ceased hospital operations but are still grantees (see Table I.1). Not all hospitals reported all the information used in the analysis; the actual number of hospitals reporting is noted on the individual tables.

TABLE II.1
MANAGEMENT CHANGES
1989 GRANTEES

Management Change	Distribution
Administrator	
Administrator Changed at Least Once	32.3 % ^a
Administrator Changed at Least Twice	7.5 % ^a
Contracted Management	
Hospital Added Contract for Management Services	3.1 % ^b
Hospital Stopped Contract for Management Services	3.1 % ^b
Hospitals with Contract for Management Services	28.8 % ^b
Multi-Hospital System	
Hospital Joined a Multi-Hospital System	1.2 % ^b
Hospital Left a Multi-Hospital System	3.7 % ^b
Hospitals in Multi-Hospital Systems	21.5 % ^b

NOTE: The total number of hospitals reporting is 166. 161 hospitals reported administration data and 163 hospitals reported contract management and hospital system data.

^aMeasured from the time the proposal was submitted—an 18 month period.

^bMeasured from the time the grant started—a 12 month period.

administrators of one fourth from 1986 to 1987--a rate that the hospital industry viewed as very high relative to prior history.²

A few hospitals changed their managerial organizational structure. Although there was no net change in the number of grantees with outside managerial contracts (29 percent of grantees), 3 percent of the 1989 grantees (five hospitals) added contract management services during the first year of the grant program while the same percentage dropped managerial contracts. The number of grantees in a multi-hospital system decreased slightly during the first year of the grant program. One percent of the grantees (two hospitals) joined a multi-hospital system during the first year, so that 22 percent were in a multi-hospital system at the end of the year. Four percent (six hospitals) left a multi-hospital system during the period.

These data suggest that the management structure of the grantee hospitals is in flux. The grantees had high administrator turnover. Furthermore, the number of grantees in multi-hospital systems declined, just as it did for all rural hospitals during 1985-1987³. Finally, there was also turnover in the hospitals operating under management contracts, although the proportion of management contracts among grantee hospitals

²OTA-H-434, p. 161.

³OTA-H-434, p.173.

remained steady. In contrast, the number of rural hospitals operating under management contracts nationwide grew by 5 percent per year from 1984 to 1987.⁴

2. Changes in Physician Staff

When the grants were awarded, 54 percent of the hospitals were trying to recruit physicians, and physician retention was a general goal. Over the first year of the grant projects, 38 percent of hospitals succeeded in recruiting physicians (two per hospital), 29 percent lost physicians (1.9 per hospital), and some both recruited and lost physicians. The impact of these changes was a small net increase (0.24) in physicians per hospital (see Table II.2). The following figures show that only 27 percent of hospitals actually increased the number of physicians:

- Hospitals with a net increase in the number of physicians (27 percent)
 - 20 percent recruited; no losses
 - 7 percent recruited; fewer losses than recruits
- Hospitals with no net change in the number of physicians (57 percent)
 - 6 percent recruited; lost same number
 - 51 percent no recruits; no losses
- Hospitals with a net decrease in the number of physicians (16 percent)
 - 5 percent recruited; lost more
 - 11 percent no recruits; some losses

⁴OTA-H-434, p.113. This report also suggests that it is difficult for rural hospitals to drop outside management contracts once entered into. We saw that a small number of Rural Health Care Transition grantees (five) were able to drop such contracts.

TABLE II.2
PHYSICIAN STAFFING CHANGES OVER FIRST YEAR OF GRANT
1989 GRANTEES

Staff Change	Distribution or Mean
Percentage of Hospitals with No Physician Changes (i.e., no hires or quits)	51 %
Hospitals with Net Increase in Physician Staff	27 %
Average Net Increase in Physician Staff	1.8
Average Percentage of Physician Staff Represented ^a	38 %
Hospitals with Net Decrease in Physician Staff	16 %
Average Net Decrease in Physician Staff	1.5
Average Percentage of Physician Staff Represented ^b	29 %
Hospitals with No Net Change in Physician Staff	57 %
Average Net Change Over 1 Year	.24
Hospitals that Hired Physicians	38 %
Average number hired for those that hired physicians	2.0
Average percentage of physician staff represented ^c	35 %
Hospitals that Lost Physicians	29 %
Average number lost for those that lost physicians	1.9
Average percentage of physician staff represented ^d	27 %

NOTE: Out of 166 hospitals, 154 reported physician staffing data.

^aNet increase in physicians divided by number of physicians on staff at grant award.

^bNet decrease in physicians divided by number of physicians on staff at grant award.

^cNumber of physicians hired divided by number of physicians on staff at grant award.

^dNumber of physicians lost divided by number of physicians on staff at grant award.

Among the hospitals with an increased number of physicians on staff, size increased by an average of 1.8 physicians, representing an increase of 38 percent over the hospitals' baseline physician staff size. Even though this increase in the number of physicians is quite small, this change could play a large role in keeping the hospitals afloat. One hospital administrator estimates that each active family practitioner on staff can generate \$800,000 worth of hospital revenue. If this estimate is accurate, then the addition of 1.8 physicians for hospitals with net increases also increases the expected annual revenues at these hospitals by \$1.4 million. Since the median annual revenue in fiscal 1989 was \$4,229,361, this would represent an increase in annual revenues of 34 percent. This may not be enough to keep the hospital operating in the black; however, it certainly helps.

It should not be overlooked, however, that 57 percent of the 1989 grantees did not have any net changes in their physician staff over the first year of their grant period even though 6 percent recruited some physicians and others were trying to recruit at least one physician at the time of the grant award.

Among the hospitals that had a net loss of physicians, physician staff decreased on average by 1.5 physicians, representing 29 percent of the baseline staff. Five percent of the hospitals had net losses despite recruiting at least one physician. Furthermore, physician losses occurred disproportionately in smaller hospitals.

These physician changes show that a minority of 27 percent of hospitals have made major strides in their staffing, but a majority have had either no net change or

experienced a decrease in physician staff. These hospitals still face high recruiting costs.⁵ For hospitals that began the grant program understaffed, unsuccessful recruiting efforts may be as damaging to the hospital's viability as the loss of physicians are to those that started the program fully staffed. So, despite the success in increasing physician staff thus far, there are still major staffing problems to be addressed.

3. Changes in Nursing and Other Licensed Staff

Throughout the United States, nurse employers have complained about the shortage of nursing personnel. Because rural hospitals are typically small, however, the loss of just one nurse can cause staffing problems at the hospital. On the other hand, the addition of just one nurse can significantly alleviate a nursing staff shortage problem.

At the time of the grant award, 79 percent of the grantees were trying to recruit at least one Registered Nurse (RN) and 42 percent were trying to recruit at least one Licensed Practical Nurse (LPN). During the first year of the grant program many of these hospitals made progress towards these hiring goals. Over 50 percent of the 1989 grantees increased the number of RNs on staff, while 49 percent increased the number of LPNs on staff (see Table II.3).

The net increase in nursing staff does not fully reflect the amount of turnover. Nearly 90 percent of the grantees lost RN staff during the year and 70 percent lost LPN

⁵The cost of recruiting a family practitioner is reported to be approximately \$20,000 (when a recruiting agency is used).

staff (Table II.3). Thus, at any particular point in time, a grantee may experience a nursing staff shortage because of a recent resignation, although over this last year the grantees, on average, have been able to replace lost staff.

Turnover in allied health professionals can also create staffing problems for small rural hospitals. Hospital operations can be severely hampered if the one person from a one-person department leaves. The grantees, however, on average have successfully increased their allied health staff. Over 91 percent of the rural health grantees hired licensed/certified staff during the first year of the grant, while 84 percent lost licensed/certified staff (Table II.3). The net result is that 58 percent of the grantees increased the number of licensed/certified staff, while 18 percent decreased and 24 percent remained the same.

The types of allied health staff most frequently hired by the grantee hospitals are laboratory, radiologic and dietary personnel. These three types of staff were also the most likely to leave a hospital. However, while the number of grantees that hired and lost dietary staff is about the same, a larger proportion of grantees hired laboratory and radiologic personnel than those that lost such personnel. Sixteen percent more grantees hired rather than lost radiologic personnel, while 11 percent more grantees hired rather than lost laboratory personnel. While a number of factors could explain this change, one potential reason is that hospitals are hiring in response to the Clinical Laboratory Improvements Act, which mandates certain levels of trained staff for medical laboratories.

TABLE II.3
NURSING STAFF CHANGES OVER FIRST YEAR OF GRANT
1989 GRANTEES

Staff Change	Distribution
Nurses	
RNs	
Hospitals with net increase in RN staff	51 %
Hospitals with net decrease in RN staff	27 %
Hospitals with no net change in RN staff	22 %
Hospitals that hired RN staff	93 %
Hospitals that lost RN staff	88 %
LPNs	
Hospitals with net increase in LPN staff	49 %
Hospitals with net decrease in LPN staff	21 %
Hospitals with no net change in LPN staff	30 %
Hospitals that hired LPN staff	78 %
Hospitals that lost LPN staff	71 %
Licensed/Certified Personnel	
Hospitals with net increase in licensed/certified staff	58 %
Hospitals with net decrease in licensed/certified staff	18 %
Hospitals with no net change in licensed/certified staff	24 %
Hospitals that hired licensed/certified staff	91 %
Hospitals that lost licensed/certified staff	83 %
Type of staff most frequently hired	
Laboratory	62 %
Radiologic	50 %
Dietary	40 %
Type of staff most frequently lost	
Laboratory	50 %
Dietary	37 %
Radiologic	33 %

NOTE: Out of 166 hospitals, 161 reported nursing and licensed staff data.

Overall, we found that the grantee hospitals have increased both their nursing and certified/licensed professional staff size over the course of the year. One hospital noted that both the number of professional staff applying for jobs, and the number of part-time staff willing to work full time had increased during the year. The hospital's observation was that the willingness of present staff to increase the number of hours worked was due, in many cases, to spouses having lost their jobs. If this is the result of the economic recession and if this is the case throughout the country, the gain in personnel seen over this first year may only be temporary.

4. Changes in Number of Beds and Services

The decrease in the demand for inpatient care during the 1980s is well documented (OTA, p. 117). As a result of this decrease, many hospitals have down-sized their facilities. Indeed, one of the goals of the Grant Program for Rural Health Care Transition is to encourage such changes and help hospitals plan these changes.

The grantees have reasons and the opportunity to down-size, but only a few of them have done so. In 1989, 88 percent of the grantees had occupancy rates of less than 50 percent for staffed, acute care beds (Cheh, Condon, and Wooldridge, 1990). The average hospital has 21 empty, staffed acute care beds.⁶ Despite these low occupancy rates, only 6 percent of the grantees decreased the number of staffed, acute care hospital

⁶Empty beds are defined as the occupancy rate multiplied by the number of staffed beds, subtracted from the number of staffed beds.

beds during the first year of the grant program, and only 3 percent plan to decrease bed-size during the second year of the program (see Table II.4).

Three factors may have resulted in the low rate of down-sizing decisions. First, in States with strict Certificate of Need regulations, hospital boards fear that if they down-size they will be unable to increase the number of beds should demand for inpatient services increase in the future. Second, boards express concern that the community will view the down-sizing as a decrease in the quality of care, and thus stop using the hospital. Third, small hospitals may resist down-sizing because of a "small numbers" problem. Even if the average occupancy rate is 50 percent, in hospitals with few beds, a small change in the number of patients can dramatically change the hospital's occupancy rate. For example, in a 20-bed hospital with a 50 percent occupancy rate 10 beds would usually be vacant. A census change of only 5 patients would bring the hospital to 75 percent occupancy. Thus, in order to be prepared for such large proportional swings in patient population, hospitals may need to keep their staffed beds even if they are unoccupied most of the time.

Not only are grantees not down-sizing, many of them have expanded hospital services. Just under half of the grantees added new hospital services (mostly outpatient) during the first year of their grant project (Table II.4). The most popular service to add was a physician specialty outpatient clinic (19 percent), and the second most popular service to add was Computerized Axial Tomography (CT) scanning (5 percent). Five

TABLE II.4
BED-SIZE/SERVICE CHANGES OVER FIRST YEAR OF GRANT
1989 GRANTEES

Change	Distribution
Hospitals that Decreased Number of Staffed, Acute Care Beds	6 %
Hospitals that Plan to Decrease Number of Staffed, Acute Care Beds	3 %
Hospitals that Added Services	49 %
Most frequently added services:	
Specialty Clinics/Outpatient Services	19 %
Computerized Axial Tomography Scan	5 %
Cardiac Rehabilitation	4 %
Home Health	4 %
Magnetic Resonance Imaging	4 %
Occupational Therapy	4 %
Satellite Clinics	4 %
Hospitals that Discontinued Services	9 %
Most frequently discontinued services:	
Obstetrics-gynecology	2 %
General Surgery	1 %

NOTE: Out of 166 hospitals, 165 reported bed-size and service changes.

different services tied as the third most popular service to add by the grantee hospitals. These included cardiac rehabilitation, home health, magnetic resonance imaging, occupational therapy, and satellite clinics. This suggests that the grantees are trying a number of different alternatives to meet their communities' needs and to attract patients to their facility, but no particular service is seen by the hospital decision makers as the right one for all.

Very few grantees that were still operating as licensed acute care hospitals at the end of the first year have discontinued services. Only 9 percent of the grantees discontinued any services, with three hospitals (2 percent) dropping obstetrics and gynecology and two hospitals (1 percent) dropping general surgery.

B. CONSORTIA

Alliances among hospitals may help members to manage resources more effectively than they can alone and hence may improve financial stability. In 1987 12 percent of rural hospitals with 300 or fewer beds were members of such alliances (OTA, 1990). The Grant Program for Rural Health Care Transition accepted applications from hospital consortia as well as individual hospitals.

Numerous consortium applications for Rural Health Care Transition grants were received in 1989 and 1990, proportionately more than the number of hospitals in consortia nationwide in 1987. This high response from hospitals in consortia may reflect the growth in the number of consortia over the period, or the perception by applicants

that consortia are an effective means of maintaining viability. In 1989, 234 applications (33 percent) were from hospitals in consortia, of which 40 (in 11 consortia) were funded (22 percent of grantees). In 1990, 198 applications (39 percent) were from hospitals in consortia, of which 61 (in 16 consortia) were funded (29 percent of grantees).

1. Consortium Participation Among 1989 Grantees

To establish the range and purpose of consortia to which grantee hospitals belong, we asked the 175 1989 grantee hospitals (177 grantees) who completed the 1-year background report whether they belonged to a consortium and the objectives of these consortia.⁷ In addition to the 37 hospitals that belong to a transition grant consortium (39 grantees), another 42 hospitals belong to a consortium, for a total of 79 hospitals (45 percent of grantee hospitals) (see Table II.5). Rather surprisingly, 19 of the 39 hospitals funded as consortium members said that they did not belong to a consortium.⁸ The most likely explanation for this illogical response is that some of the respondents took the question to refer to membership of consortia other than their transition grant consortium. However, consortia may be structured very loosely with few ties, little coordination, and limited objectives or vice-versa. If we exclude hospital alliances that were based purely on common ownership, we would exclude one

⁷Four of the grantees are no longer operating as hospitals.

⁸These 19 hospitals were members of 9 of the 11 funded consortia.

TABLE II.5
CONSORTIUM PARTICIPATION AMONG THE 1989 GRANTEES

	Percent
Percent of 1989 Grantee Hospitals that are a Member of a Rural Health Care Transition Consortium	21 %
Percent of 1989 Grantee Hospitals that are in either a Rural Health Care Transition Consortium	45 %
Percent of 1989 Grantee Hospitals that are a Member of 2 or More Consortia	8 %
Objectives of 60 Consortia: ^a	
Professional education and development	75 %
Joint purchasing of supplies	63 %
Coordinated provision of health services	55 %
Recruitment of health care professionals	50 %
Advocacy at the State/Federal levels of government	42 %
Joint quality assurance monitoring	38 %
Shared administrative services	22 %
Defining market roles for individual hospitals	18 %

NOTE: Number of hospitals in sample is 175.

^aBased on responses of 60 consortium members. This excludes 19 hospitals that said they were not in a consortium, even though they received a grant as a member of a consortium.

consortium of three hospitals, none of whom said they were in a consortium.⁹ We return to a discussion of these grantees in the next section.

Sixty hospitals reported that they are in consortia. Of these 60 hospitals, 14 (23 percent) belong to more than one consortium. Table II.5 shows the number of grantee hospitals in a consortium using alternative definitions, the number in more than one consortium, and the consortium objectives.

More than half of the grantee hospitals in a consortium mentioned the same four goals for their consortium: professional education and development (75 percent), joint purchasing (63 percent), coordinating services (55 percent) and recruiting health professionals (50 percent). Moscovice et al., (1989) also found that the most common goal of rural hospital consortia was professional education and development (81 percent of consortia).

2. Characteristics of the Consortia Funded by the Program for Rural Health Care Transition in 1989

The 11 consortia that were funded by the Program for Rural Health Care Transition in 1989 vary in size, longevity, type of ownership and management, and amount of coordination. There are 37 hospitals, two of which have two grants and are in two consortia.^{10,11} Most (24) of these hospitals are in consortia with three or four

⁹The American Hospital Association excluded from its 1987 count of hospitals in alliances any that were based purely on common ownership.

¹⁰The two hospitals with two consortium grants each receive less than \$50,000 per year, the maximum funding.

members; six are in consortia with two members and nine are in a single consortium.

(See Table II.6.)

Alliances or consortia of rural hospitals are a fairly recent development.¹¹ Four consortia reported that they were established to apply for the transition grant program. The remaining seven consortia were founded between 1986 and 1989 (although two of these consortia started after receiving their transition grant awards).

Although we expected that some of the consortium members would have existing ties through membership of multi-hospital systems or management contracts, most (28) of the 37 consortium members are independent hospitals of which only eight have management contracts with outside organizations. Nine of the consortium members belong to multi-hospital systems, but other members of their consortium are drawn from these systems in only two consortia (representing five hospitals).

3. Factors Affecting Potential Success

Success in maintaining a consortium depends on the goals of the consortium, the extent to which these goals require coordination and financing and the commitment of the participating hospitals.

¹¹One grantee closed as a hospital in the first 6 months of the project and is no longer receiving a grant. One of the 37 grantees included in the discussion has also closed as a hospital but continues as a grantee, using its grant to plan ambulatory and long term care service delivery in the community.

TABLE II.6

OWNERSHIP AND ORGANIZATION OF HOSPITALS IN TRANSITION GRANT
CONSORTIA
1989 GRANTEES

Characteristic	Distribution	Percent
Number of Consortium Projects Funded by Rural Health Transition Grant Program	11	100%
Distribution by Size:		
2 hospitals	3	27%
3-4 hospitals	7	64%
9 hospitals	1	9%
Distribution by Date Established:		
Established prior to Rural Health Care Transition grant program	7	64%
Established for Rural Health Care Transition grant program	4	36%
Distribution of Consortium by Structure:		
Consortium has a lead hospital	3	27%
Consortium has a coordinator	11	100%
Distribution of Consortium Hospitals Management Affiliation: ^a		
Independent hospitals	28	76%
Multi-hospital system	9	24%
Contract management	8	22%

^aNumber of hospitals reporting is 37.

More than half of the consortia funded by the Rural Health Care Transition grants have the goals of coordinating services (8), recruiting health professionals (7), and professional education and development (7). Goals which require administrative integration such as joint quality assurance are less common (4). Joint purchasing of supplies is a goal of only two consortia. Table II.7 shows these goals relative to two other groups of hospitals: other transition grantees in consortia and rural hospital consortia nationwide in 1989. We see three leading goals in all three consortium populations: coordinating services, professional education and development, and recruiting health professionals. Thus the transition grant consortia appear to be similar to other rural hospital consortia in their goals.

Formal coordination and communication mechanisms among members vary in frequency and effectiveness. All the consortia have a coordinator but only three have chosen to have a lead hospital for the consortium. Six consortia meet once a month or more, and two of these meet every week (see Table II.8). All but three of the hospitals involved in consortia consider consortium communication to be effective all or most of the time. The three hospitals that consider communication only occasionally effective are from two different consortia, both of which meet less often than monthly.¹²

¹²The consortium with two members (of a total of four in the consortium) who consider that communication is effective only occasionally has diverse and loosely specified goals and a very small Rural Health Care Transition grant. These two members also felt that they had not benefited from their transition grant project.

TABLE II.7
GOALS OF CONSORTIA
1989 GRANTEES

Goal	Transition Grant Consortia ^a	Grantees in Any Consortium ^b	120 ^f Rural Hospital Consortia ^c
Distribution of Consortia by Goal:			
Coordinated provision of health services	73 %	55 %	80 %
Professional education and development	64 %	75 %	81 %
Recruitment of health care professionals	64 %	50 %	55 %
Joint quality assurance monitoring	46 %	38 %	42 %
Advocacy at the State/Federal levels of government	46 %	42 %	-
Defining market roles for individual hospitals	36 %	18 %	-
Shared administrative services	27 %	22 %	-
Joint purchasing of supplies	18 %	63 %	-

^aNumber of consortia reporting is 11.

^bSixty Rural Health Care Transition grantees reporting that they belonged to a consortium.

^cReported by I. Moscovice et al., 1989.

TABLE II.8
COMMUNICATION AMONG CONSORTIA HOSPITALS
1989 GRANTEES

Communication Measure	Distribution
Percent of Consortia that Meet: ^a	
More than once per week	18.2 %
Less than once per week but more often than once per month	18.2 %
Once per month	18.2 %
Less than once per month but more often than annually	54.5 %
Percentage of Hospitals who Respond that Consortium Communication is Effective: ^b	
Always	61.5 %
Most of the time	30.8 %
Occasionally	7.7 %

^aNumber of consortia reporting is 11.

^bNumber of grantees reporting is 39.

Consortium financial support varies in type, amount, and purpose. Annual Rural Health Care Transition funding for specific projects varies from \$5,555 per member to \$50,000 per member (average \$37,733) with annual consortium totals ranging between \$37,500 and \$200,000 (average \$116,841). Many of the consortia have other funding in addition to the Rural Health Care Transition grant funding. These funds are used both for administering the consortium and for joint projects. Four consortia raise funds through member dues, six have revenues from joint projects (such as service reimbursement), four have another grant, and three mentioned individual hospital support for programs and administration. Only six of the consortia operate with a set annual budget for administration and joint projects. These budgets range between \$100,000 and \$300,000 and support from one to five consortium staff. See Table II.9.

Even among consortia, members compete with one another: 59 percent of the hospitals, from nine of the 11 transition grant consortia, compete with fellow member hospitals for both patients and professional staff. This level of competition is not surprising since eight of the consortia were developed because of geographic proximity. Concern about competition does not seem high; indeed, all nine of the consortia in which competition occurs are open to all the hospitals in their areas.¹³ See Table II.10.

Competition does not appear to have impaired the effectiveness of the consortium grant projects. Ninety percent of the consortium members felt that their consortium

¹³One consortium of two hospitals has extended its membership to four other hospitals, none of which are Rural Health Care Transition grantees.

TABLE II.9
FINANCIAL CHARACTERISTICS OF CONSORTIA
1989 GRANTEES

Financial Characteristics	Distribution or Mean
Number by Source of Consortium Funding: ^a	
Only Rural Health Care Transition grant	1
Dues	4
Revenues from joint projects	6
Other grants	4
Member support	3
Number of Consortia with a Set Budget	6
Average current fiscal year budget	\$199,500
Minimum	\$100,000
Maximum	\$300,000
Rural Health Care Transition Funding:	
Annual Average per member	\$37,733
Minimum	\$5,555
Maximum	\$50,000
Annual Average per Consortium	\$116,841
Minimum	\$37,500
Maximum	\$200,000

^aNumber of consortia reporting is 11.

TABLE II.10
COMPETITION AMONG CONSORTIUM MEMBERS
1989 GRANTEES

Measure of Competition	Number	Percent
Number and Percent of Consortium Hospitals that Compete with Other Consortium Members	23	59% ^a
Number and Percent of Consortia within which Hospitals Compete	9 ^b	82% ^c
Number and Percent of Consortia based on Geographic Proximity	8 ^d	73% ^c

^aBased on 39 grantees, of whom 2 belong to 2 consortia and are counted once in each.

^bWithin 5 of these consortia (including 16 hospitals) 7 hospitals considered themselves in competition and 9 did not.

^cNumber of consortia reporting is 11.

^dIn five of these areas, there are other local hospitals which do not currently belong to the consortium, but which could join the consortium if they wanted to.

project had benefited them. For example, hospitals in one consortium that updated its management information system had found that management benefited from improved financial and service use information. Of the four hospitals (in two consortia) who felt they had not benefited from their consortium project, three gave no reason and one said it had lost money on the service introduced by the joint project (teleradiology). Two of the hospitals that had not benefited had also indicated that consortium communication was only occasionally effective.

4. Conclusions

One fifth of Rural Health Care Transition grantees belong to consortia funded by Rural Health Care Transition grants. Based on self report, most consortia appear to coordinate and communicate effectively, and 90 percent of those hospitals funded as consortium members consider they have benefited from their projects. These data suggest that consortium grant projects may be successful. Their self-reported progress (described in the next chapter) is consistent, and more consortium grantees are on schedule than individual hospital grantees.

III. PROGRESS OF 1989 GRANTEES

In OBRA 1987, Congress mandated that HCFA report to Congress on the progress of the Rural Health Care Transition grantees every 6 months. A monitoring process was designed to ensure that grant funds were expended in a manner consistent with achieving the project goals and in accordance with regulations. The monitoring process is used to inform both HCFA and the Congress on the use of grant funds under the program, and on the grantees' progress towards meeting their goals.

The monitoring process incorporates two activities. First, grantees must submit a report every 6 months that describes progress and documents grant expenditures. Second, site visits are being made to 50 of the 1989 grantees, 20 of which were completed before this report was prepared.

Under the terms and conditions of the grant awards, grantees are required to report the amount of grant funds spent and the progress made on their projects every 6 months. The third report from grantees, which covered the period October 1, 1990, through March 31, 1991, was due on April 20, 1991. Of the 169 participating hospitals, 146 completed reports in time to be processed for this Congressional Report.¹ The information presented in this chapter is based upon the self-reported progress of these 146 grantees.

¹Since the report was prepared, 165 monitoring reports were received.

Overall, the hospitals made solid progress in the past 6 months. Significant progress was made in completing construction or renovation activities and converting acute care beds to swing beds. As they have in the past, hospitals attribute their success to the availability of financial resources, cooperation with other providers, dedication of hospital staff, and strong demand for the grant-supported services. The two main reasons that projects have fallen behind schedule are difficulty recruiting health care professionals and a lack of cross-organizational support. The inability to recruit health care professionals has been a problem for the grant projects since they started. The grantees have spent most of their grant monies on personnel, contracts, and capital items.

A. ACHIEVEMENTS

1. Progress Relative to Schedule

Eighteen months after the 1989 grantees received their Rural Health Care Transition awards, 171 grants (169 hospitals) are still active. Forty-nine percent of the reporting grantees are on schedule, and 50 percent are behind schedule. Only one project is ahead of schedule with respect to all of its activities. The grantees' progress has slowed in the past 6 months; the proportion of hospitals that are behind schedule increased from 43 percent at the end of 1 year to 50 percent (see Table III.1).

Each grant project may have multiple activities some of which are behind schedule while others are on or ahead of schedule or completed. Numerous project activities have been completed after 18 months. Over 50 percent of the

TABLE III
DISTRIBUTION OF PROJECT TIMELINESS BY PROJECT OBJECTIVE AND
WHO DIRECTS PROJECT: 1989 GRANTEES¹

Characteristic	Total	Ahead of Schedule	On Schedule	Behind Schedule by More than One Month	Completed
Project Objective					
Planning or Market Analysis	59	0 %	46 %	9 %	46 %
Construction or Renovation	55	0 %	20 %	27 %	53 %
Equipment Purchase	94	2 %	39 %	16 %	43 %
Recruiting	100	0 %	33 %	31 %	36 %
Training or Staff Development	95	1 %	65 %	15 %	19 %
Education, Prevention, or Wellness Programs	54	0 %	76 %	11 %	13 %
Inpatient or Hospice Service	23	4 %	35 %	26 %	35 %
Outpatient Service	43	2 %	51 %	28 %	19 %
Clinic	31	0 %	36 %	23 %	42 %
Emergency Medical Services	12	0 %	58 %	17 %	25 %
Swing Beds	7	0 %	29 %	14 %	57 %
Other Health Service	14	7 %	50 %	29 %	14 %
Rural Health Network	36	3 %	36 %	25 %	36 %
Other	23	4 %	57 %	22 %	17 %
Who Directs Project?					
Hospital Administrator	88	1 %	51 %	48 %	0 %
Another Staff Member or Outside Consultant	56	0 %	48 %	52 %	0 %
Multiple Project Directors	2	0 %	0 %	100 %	0 %
Total	146	1 %	49 %	50 %	0 %

NOTE: Totals may not add to 100 percent due to rounding error. Only grantees who were still active at the end of 18 months are included.

¹Project timeliness is defined by the project's most delayed activity. For example, a project that is on schedule in only one activity and ahead of schedule in all the rest is defined to be on schedule.

construction/renovation activities and swing-bed conversions have been completed. The completion rate for the construction and renovation activities has increased significantly in the past 6 months--at the 1 year mark, none of the grantees reported that they had completed construction or renovation activities. Over 40 percent of the planning and market activities, equipment purchases, and clinic development activities have been completed as well.

In contrast, less than 20 percent of the training or staff development activities, education programs, outpatient services, or other health service activities have been completed. However, the majority of these activities are on schedule. Since these types of activities are likely to be on-going activities that can be spread over the life of the grant, it is not surprising that they are not completed.

The activity that is most likely to be delayed is the recruiting of health care professionals; 31 percent of the grantees are behind schedule in meeting recruiting objectives. Six months ago, 42 percent of the 1989 grantees were behind schedule in meeting recruiting objectives, so it appears that progress has been made. Hospitals are behind in recruiting for two predominant reasons: (1) the grantees had unrealistic expectations about how long the recruitment process would take, and (2) the hospitals have not been able to identify appropriate personnel either in the area or willing to relocate to the area.

Just as we found earlier, there is a slight correlation between being on schedule and the position of the person administering the project. More of the projects directed

by the hospital administrator are on schedule (51 percent) or ahead of schedule (1 percent) than those directed by other staff members (48 percent).

2. Operational Successes and Difficulties

Successes. Hospitals have attributed their success after 18 months to a number of factors. The most frequently cited factors are:

- Availability of financial resources (cited by 60 percent)
- Cross-organizational support (cited by 60 percent)
- Dedication of the hospital staff (cited by 54 percent)
- Project fills a demand for health care services (cited by 53 percent)

The first three factors in success are very similar to those cited at the end of the first year. However, more hospitals are now attributing the success of their project to the project filling a demand for health care services. This increase is most likely because more grant-funded service projects are now operating, word has reached the community, and staff can see how many clients are using the new services.

The financial resources provided by the grant continue to be cited by many grantees as the primary reason for the success of the project. One hospital that successfully recruited a physician noted that the funds made it possible to support the physician during the practice building stage, and this financial support was instrumental in attracting the physician to the area. Another hospital stated that the funds allowed the

hospital to do the extra things to help position itself for the future, and without the funds it would have only been able to maintain the status quo.

As the projects build momentum, many hospitals report that other organizations have become much more enthusiastic in their support. One hospital noted that, after seeing progress made on the project (including a Certificate of Need application and management reorganization), the local newspaper has written supportive editorials which have increased the community's financial support of the hospital. Area medical schools have provided both leadership and clinical support to the grant projects, which have helped the hospitals gain credibility.

Over half of the hospitals cited staff dedication as a factor in their success. At one hospital, members of the staff who have completed training courses as part of the project have voluntarily participated in further related training outside of the hospital. A consortium that is operating a staffing network has found that more employees have participated in the network than had originally volunteered, and these employees have willingly travelled to other hospitals in order to help meet staffing shortage problems.

Fifty-three percent of the hospitals have found that the demand for the services being provided by the grant project has made the project more successful than originally hoped. One hospital had to hire more home health care staff than originally planned in order to keep up with the growing demand for the service. Another hospital reported that it has already expanded its cardiac rehabilitation services in order to meet the area's demonstrated need.

Difficulties. Although many hospitals are pursuing their projects successfully, problems have also been encountered. The two most frequently cited problems are inability to recruit health care professionals (32 percent) and lack of cross-organizational support (32 percent). Hospitals are also encountering financial constraints (19 percent) and a lack of demand for the services developed by the project (17 percent).

Difficulties recruiting professional staff have hindered grantee progress since the program first began. The inability to recruit nursing personnel in particular has hurt a variety of projects. One hospital that has been unable to recruit nurses for its hospice project has had to increase the workload on the present staff, increasing emotional stress on the present staff. A home health project that has been very successful at recruiting patients has been hindered because the hospital cannot recruit enough nurses who want to work in peoples' homes. A hospital that is operating a physical therapy clinic has also found a larger than anticipated demand for its services, but it has not been able to recruit more physical therapists in order to meet the demand. Finally, one hospital has enlisted 17 recruiting firms in its search to bring a second physician to the area, but thus far has been unable to recruit one.

Close to a third of the grantees have also encountered lack of cross-organizational support. Hospitals have found that many established physicians view new physicians as a threat to their practices, and thus the established physicians have not been cooperative in recruiting new physicians. Another hospital met resistance from local charity organizations to its program to provide registered nurses with emergency medical training.

The organizations argued that nurses have enough training and providing them with emergency medical training was wasting valuable resources. Another category of external support is assistance from Federal agencies in program implementation. One hospital reported that it had been unable to obtain information on respite care program regulations from Federal authorities, which slowed the implementation of its project.

Nineteen percent of the hospitals cited funding problems as a deterrent to their projects' success. In some instances, the grantees overestimated the amount of financial support that they could generate from their community. As a result the hospitals have had to continue fund-raising instead of implementing their projects. One hospital severely underestimated how much overtime staffing would be required for its project, resulting in cost overruns and cutbacks in the program. Other hospitals have stated that State cutbacks in Medicaid payments have created unanticipated financial shortfalls, forcing the hospitals to spend internal financial resources intended for the project on daily operations.

Seventeen percent of the hospitals have found that the community has not used the services provided by the grant project. (Over 70 percent of the grantees are enhancing emergency or outpatient services, while 12 percent are initiating inpatient services (see Cheh, Condon, and Wooldridge, 1990)). One hospital has already decided to discontinue its outpatient surgery because surgery volume was low and the hospital thought that the unsuccessful program may negatively affect the reputation of the entire facility. Another hospital has reduced the operating hours of its off-site convenient care

center because of the lack of patient demand. Attendance has also been low for many of the patient-education programs, despite the hospitals' out-reach efforts.

B. PROJECT MODIFICATIONS

Three of the 1989 grantees made project modifications after delaying their projects for a full year. Two hospitals had to change from their original intent because they could not recruit the personnel necessary to undertake the projects. In the third case, the hospital had planned a joint project with a Veterans Administration (VA) hospital to open an outpatient clinic for veterans, but budget cuts at the VA hospital rendered its commitment to the clinic unfulfillable.

Other hospitals have made project modifications because of unexpected financial gains or losses. In one case the hospital had overestimated the amount of money it needed to form a consortium, so the extra funds are now being used to support physician education. Another hospital found that the cost of keeping an urgent care clinic open 24 hours per day was beyond its financial capabilities. As a result, the hospital used the grant funds to increase daytime clinic services, and the county government used the funds it had committed to the project to increase the availability of emergency transportation services.

C. EXPENDITURES

HCFA awarded \$8,254,442 in first year Rural Health Care Transition grants to 181 hospitals in September 1989. Because four hospitals left the program and others

requested budget changes, the net total of obligated funds in fiscal 1989 was \$8,104,443. In August of 1990, HCFA awarded \$7,408,072 in continuation grants to 172 of the 1989 grantees, increasing the total amount of obligated funds to \$15,512,515. Two grantees closed their facilities and withdrew from the program since the fiscal 1990 awards were made, decreasing the amount of obligated funds to \$15,412,515. Eighteen months after the original awards were made, \$9,516,436 had been spent by the 146 reporting hospitals, accounting for 61 percent of the total amount of obligated grant funds.

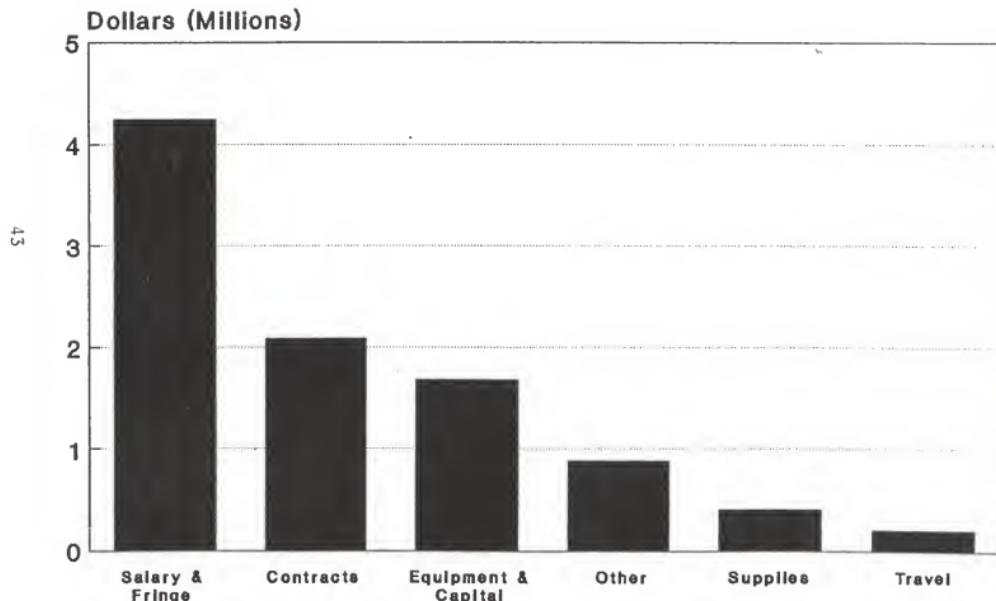
Figure III.1 shows the categories of grant expenditures after 18 months. The majority of the expenditures fall into three categories:

- Personnel: \$4,246,239 (45 percent)
- Contracts: \$2,089,269 (22 percent)
- Capital: \$1,680,870 (18 percent)

This distribution of expenditures is almost exactly the same as it was at the end of the first year. The proportion spent on personnel has increased slightly from 41 percent to 45 percent of total reported expenditures, but otherwise the proportion of funds spent on these categories is about the same.

Eighty-six percent of the 1989 grantees (126 hospitals) have spent more than 50 percent of their 2-year allocation, with 40 percent (59 hospitals) having spent more than 75 percent (see Figure III.2). At the other extreme, 3 percent of the grantees (four

FIGURE III.1
Total Expenditures After 18 Months
by Category: 1989 Grantees



hospitals) have spent less than 25 percent of their awards. As illustrated in Table III.2, rate of expenditure appears to be related to the progress of the project--all of the grantees that have spent less than 25 percent of their grant funding are behind schedule by more than 1 month. In addition, 69 percent of the grantees that have spent between 26 and 50 percent of their grant funds are also behind schedule, suggesting that the slow spending rates may be correlated with the progress of the grant project.

D. PROGRESS BY THE CONSORTIA HOSPITALS

As we discussed earlier, the consortium projects have generally had effective inter-hospital communication, and 90 percent of the hospitals in consortia felt that their consortia had benefited them after 1 year. After 18 months, we find that 70 percent of the hospitals that are part of an active consortium project are on schedule with respect to all activities, in contrast to 44 percent of the individual grantee hospitals. One consortium project has completed its teleradiology project. The consortium projects that are active have spent, on average, 83 percent of their allocated grant funds. This suggests that, consistent with our expectations, the consortium projects are progressing more smoothly than the individual hospital projects.

E. HOSPITAL CLOSURES

Seven Rural Health Care Transition grantees closed their inpatient acute care services during the first 18 months of the grant program. Nationwide, 50 community

FIGURE III.2
Percentage of 2-Year Funding Spent
After 18 Months: 1989 Grantees

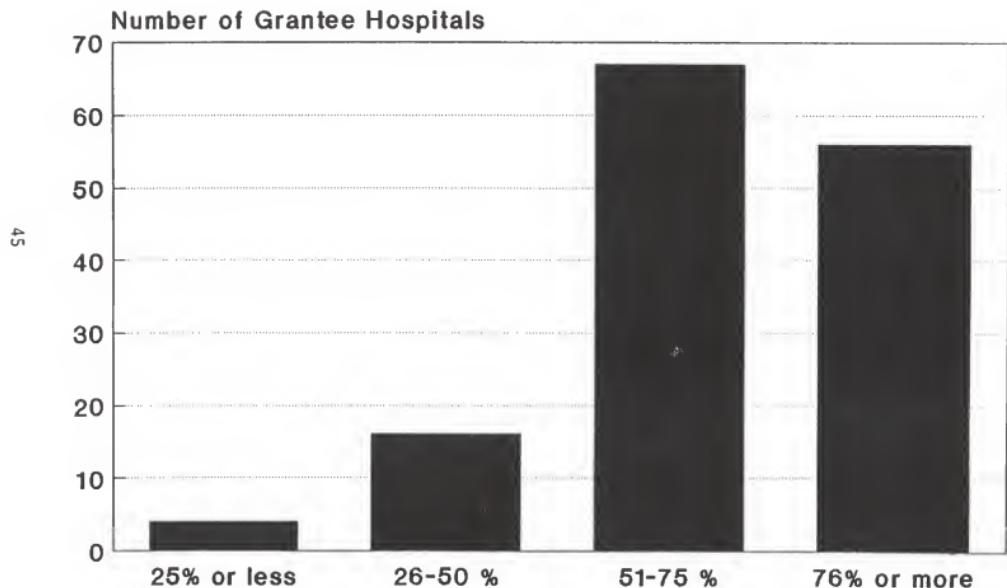


TABLE III.2
PERCENTAGE OF GRANT FUNDS SPENT BY PROJECT TIMELINESS: 1989 GRANTEES¹

Percent of Total Grant Funds Spent After 18 Months	Total Number	Ahead of Schedule	On Schedule	Behind Schedule by More Than One Month	Completed
25 percent or less	4	0 %	0 %	100 %	0 %
26 - 50 percent	16	0 %	31 %	69 %	0 %
51 - 75 percent	67	2 %	56 %	42 %	0 %
Greater than 75 percent	59	0 %	49 %	51 %	0 %
TOTAL	146	1 %	49 %	50 %	0 %

NOTE: Totals may not add to 100 percent due to rounding error.

¹Project timeliness is defined by the project's most delayed activity. For example, a project that is on schedule in only one activity and ahead of schedule on all the rest is defined to be on schedule.

hospitals closed in 1990, 28 of which were located in rural areas (AHA, 1991). How these hospital closures affect access to care is a critical issue for both the evaluation of the grant program and for health care policy. If hospital closures limit access to health care services in local areas, then a rural hospital closure would imply that the grant project failed. If the closure of the local hospital does not affect access to care, it could be considered a successful transition.

To understand how the closure of the grantee hospitals has affected access to care, we examined the seven Rural Health Care Transition grantees that closed their acute care facilities since receiving their grants. The grant projects at four of these hospitals were to plan and implement conversion to another type of health care facility. One hospital only proposed to use its grant to convert the hospital after tax support to keep the hospital open was denied by voters. None of the other three hospitals planned to convert the hospital to another facility at the time they closed.²

It is difficult to measure the impact of rural hospital closures on access to care because the effects of the closures may not become evident until long after the hospital has closed. However, a number of questions can be addressed in the short run. These are:

- What proportion of the population bypassed the local hospital for services prior to the hospital's closure? If the majority of the potential patients were already

²The pre- and post-closure data used in this section were self-reported by the hospital. Data was collected from two site visits and from telephone interviews. One hospital submitted all of the required information in its monitoring reports.

receiving health care services from another institution, then the hospital's closure may not significantly affect access to health care.

- What was the predominant reason for the hospital's closure? If the hospital closed because of a shortage of professional health staff, then the hospital's closure will not greatly affect access to health care since the area would have had limited access to professional staff even if the facility were still open. However, if the hospital was fully staffed but closed because of poor management, then the impact on access to care may be more severe.
- What efforts did the community make to keep the hospital from closing? If the community was unwilling to support the hospital, then it may be that the community did not view the hospital as an integral part of the area's health care system.
- What happened to the facility after the hospital closed? If the facility is still being used to provide outpatient and long-term care services, then the impact on access may be minimal.

1. Patient Out-Migration

For the majority of Rural Health Care Transition grantees that closed, a substantial number of the local residents already bypassed the hospital for other health care facilities. Four of the hospitals reported that more than 50 percent of the residents in their primary service area went elsewhere for care in the year before the grant award, and two others did not know the extent of the local out-migration. Only one hospital reported that more than 75 percent of the residents in its primary service area used the grantee hospital for services that it could provide. These figures suggest that a substantial proportion of the local residents preferred other institutions and were already receiving health care elsewhere at the time the hospital closed. Many of the transition

grantees that are still hospitals have comparably high out-migration rates--from which high risk of closure could also be inferred.

2. Primary Reason for Closure

Four of the seven hospitals said a physician shortage was the primary reason that the hospital closed. Two of these hospitals only had two physicians on staff in the year prior to receiving the grant, and one hospital had only one physician on staff (see Table III.3). The remaining hospital had eight physicians on staff, but the majority of the physicians were from out of the area and only one physician regularly admitted patients to the hospital. One hospital that had two physicians on staff decided to close the hospital after one of the physicians, who had only recently been recruited, decided to leave the area.

The four hospitals reporting that the lack of physicians was the primary reason for closure also had low occupancy rates. Three of the four hospitals reported occupancy rates of less than 20 percent, and two had less than 6 percent (see Table III.3). The one hospital that closed upon hearing of the loss of its newly-recruited physician had a 50 percent occupancy rate in the year that the physician was there, but the hospital administration expected that the occupancy rate would fall dramatically once the physician left the area.

TABLE III.3
 CHARACTERISTICS OF CLOSED HOSPITALS
 AT TIME OF GRANT AWARD
 1989 GRANTEES

Hospital	State	Bed Size	Average Occupancy Rate	Number of Physicians on Staff	Primary Reason for Closure	Services Now Provided
Caledonia Health Care Center*	MN	18	6 %	2	Physician Shortage	Clinic/Nursing Home/Assisted Living
Coming Community Hospital	AR	24	40 %	4	Staffing Regulations	----
LaHarpe Hospital Association*	IL	15	2 %	--	Low Occupancy	Clinic/Nursing Home
Presbyterian Family Health Care*	NM	25	15 %	13	Low Occupancy	Clinic
Salamanca District Hospital	NY	40	18 %	8	Physician Shortage	Chemical Dependency Services/Physical Therapy Services
St. Luke's Hospital	LA	26	50 %	2	Physician Shortage	Psychiatric Hospital
St. Mary's Hospital and Home*	MN	21	4 %	1	Physician Shortage	Clinic/Nursing Home

*Indicates the transition was planned with Rural Health Transition Grant Funds.

Two other hospitals reported that low occupancy rates were the primary reason that the hospital closed. Both hospitals had occupancy rates of 15 percent or less. Thus, among the six hospitals that cited either a physician shortage or low occupancy rates as the primary reason for closure, five had occupancy rates of 18 percent or less, while the sixth hospital anticipated a fall in its occupancy rate. This correlation between low-occupancy and hospital closure is consistent with the findings of other researchers (GAO/HRD-91-41). These figures suggest that the six hospitals were not highly utilized and their closure would not have had a large impact on access to inpatient care.

Although these grantee hospitals were not fully utilized, some served a disproportionate share of Medicaid patients. In 1984, the average rural hospital received 9.6 percent of its revenue from Medicaid.³ At four of the seven closed hospitals the proportion of Medicaid inpatient days exceeded 20 percent. This is consistent with previous research that showed that hospitals with more than 11 percent Medicaid inpatient days were more likely to close (GAO/HRD-91-41). Thus, while these hospital closures do not appear to affect access to acute inpatient care for the overall population, subgroups of the populations, particularly the poor, may have reduced access to care.

Medicare patients may also be affected by these closures. At these seven hospitals, the average proportion of Medicare admissions was 46 percent (ranging from 15 to 69 percent). This is comparable to rural hospitals nationally in 1986--the average

³OTA-H-434, p. 132.

rural hospital received 41.9 percent of its revenue from Medicare.⁴ Thus, these hospital closures may affect access to acute inpatient care for the Medicare population.

One hospital did not fit the above trend of low physician staffing and low occupancy rates. This hospital had four physicians on staff and a 40 percent occupancy rate in the year prior to receiving the grant. This hospital reported that the primary reason the hospital closed was the high fixed costs of Federally mandated staffing requirements. As a result of these high fixed costs, the hospital lost money. Unsuccessful efforts were made to find a buyer, and ultimately the hospital had to close. The relatively high occupancy rate suggests that the community was using the facility at the time of the closure and the impact of the closure on access to care may be substantially different in this community than in the other six communities.

3. Community Support

Although in all cases the community expressed verbal support for the hospital, none of the hospitals reported strong financial commitment from the local community to keep the hospital open. In two cases, the hospitals belonged to multi-hospital systems and the communities appear to have felt that the systems should continue to fund the hospital with profits from other hospitals, and thus the communities would not commit financial resources to the hospitals (tax support was specifically sought and refused). In another case the local government told the hospital that it would prefer that the hospital

⁴OTA-H-434, p. 132.

closed instead of providing it funds in these difficult financial times. Other institutions reported that they did not even try to obtain financial support from the local community to keep the hospital open; they felt that the community was either too poor or too unwilling to provide enough financial support to make the hospital financially sound.

4. Services Presently Provided

Another measure of how these hospital closures affect access to care is to evaluate what services remain after the closure. Six of the seven closed hospitals are now providing some type of health care, and the remaining facility was only recently closed and may still be converted in the future. Four of the closed hospitals used their transition grant funding to plan their transitions; all four are providing clinic services and three are providing nursing home services (all three offered nursing home services prior to their closure). Of the other two hospitals that are still providing services, one is providing inpatient and outpatient chemical dependency services and physical therapy services, and another has been converted to a psychiatric hospital (see Table III.3). The relatively high number of clinics and nursing homes operated by grantees (all of which used transition grant funding for the conversion) contrast with national data on community hospitals that closed in 1990. These data showed that, out of the 50 hospitals that closed, only 20 percent continued to provide outpatient services and 12 percent continued to operate nursing homes (AHA, 1991).

As we can see in Table III.3, two of the hospitals that cited a physician shortage as the primary reason for closure are now providing either specialized health care services or nursing home services, and another two are providing clinic services. However, one closed hospital reports it is still trying to recruit a physician for its clinic. The two hospitals that cited low occupancy rates but did not cite the lack of physicians as the primary reason for closure are now providing clinic services. This suggests that the types of services that will be offered after closure may depend on the type of health care professionals available. Thus, the closure of the hospital may not hamper access to primary care if clinics can effectively retain the physician staff already practicing in the area.

Among the hospitals' spokespersons, however, the hospital closures were viewed as restricting access to care regardless of the type of facility that took its place. The primary concern was that the hospital's closure limited access to emergency medical care. Residents now have to travel between 10 and 45 minutes to reach the closest hospital, a distance that the spokespersons felt could mean the difference between life and death. In fact, two of the clinics reported that they are open for extended hours to improve access to emergency care. As one spokesperson pointed out, having any type of facility in the area can improve access to emergency care services. In that particular community, a local couple came to the converted facility with a "blue" baby, and the nurses at the facility were able to resuscitate the child. As the spokesperson noted, "It isn't a hospital, but it worked."

5. Effect of the Grant

The four hospitals that used their Rural Health Care Transition grant funds for conversion into another type of institution had lower utilization levels than the other closed grantees. Two of the facilities using transition grants to convert their facilities reported that they lost more than 75 percent of their patients to out-migration, and two had occupancy rates of 4 percent or less. These data suggest that the hospitals that used grant funds to convert to another type of institution were facing a clear lack of demand for their acute care services and that the closure of these facilities was unlikely to affect access to inpatient care very much. In addition, three of the four facilities with grant-supported conversions had less than 11 percent of their admissions from Medicaid, suggesting that this subpopulation would not be disproportionately affected by the closure. Two of the four facilities with grant-supported conversions had more than half of their admissions from Medicare, but both facilities are still providing nursing home care and are now focusing their projects on the elderly. This suggests that access for the Medicare population is likely to be maintained.

The four grant-supported transitions all resulted in clinic services offered at the hospital facility (Table III.3). Two of the three hospitals that did not plan their conversions are now used for specialized health care services, and the third has not yet been converted. Thus, it appears that the hospitals that plan their closure are more likely to keep primary care services at the local hospital in contrast to those that do not

plan their transition. To the extent that the grant program is encouraging hospitals to do this planning, the program may help keep access to primary care in areas that may have otherwise lost such services. It still remains to be seen if these clinics can be both financially viable and retain physicians in the area.

IV. PROGRESS OF 1990 GRANTEES

Funding was provided for Rural Health Care Transition grants to 211 hospitals in fiscal 1990. The same monitoring process described in Chapter III for the 1989 grantees is being used to monitor these grantees.

Of the 211 hospitals awarded Rural Health Care Transition grants on September 15, 1990, only two have voluntarily withdrawn from the program. Of the remaining 209 hospitals, 187 (recipients of 188 grants) hospitals submitted their progress reports in time to be included in this report. Eighty-four percent of the hospitals had projects that involved both planning and implementation activities, 5 percent had planning-only projects, and 11 percent had implementation-only projects. Slightly over a half (53 percent) of the reporting hospitals had projects that were new initiatives.

The 1990 grantees had a slow start. Six months after receiving their grant awards, 61 percent report that they are behind schedule. The primary reason for the slow start has been the inability to recruit personnel. Of the 39 percent of grantees that are on or ahead of schedule, some have been successful in their recruiting tasks. Other reasons for successful startup are strong strategic plans, cross-organizational support, and the availability of funds.

A. ACHIEVEMENTS

1. Progress Relative to Schedule

Six months into their projects, 3 percent of the grantees (five hospitals) were at least a month ahead of schedule in all their project activities and another 36 percent

(68 hospitals) were on schedule in all their activities. The majority, 61 percent of the grantees (115 hospitals), were a month or more behind schedule in at least one activity, many because of delays not anticipated during the planning stage. In contrast, 47 percent of the 1989 grantees were behind schedule at the same point in their grant projects.

Activities over which the hospitals have a high degree of control were more likely to have been completed (see Table IV.1). These include activities such as establishing new swing bed services, planning/market analysis, and equipment purchases. Of the nine hospitals establishing swing bed services, a third have completed the activity. Approximately 31 percent of the hospitals with a planning/market analysis and 27 percent that are purchasing equipment have completed these activities. Surprisingly, 30 percent of recruiting activities had been completed, an area of activity in which hospitals often fall behind schedule.

Hospitals implementing new services were often on or ahead of schedule. Nearly 85 percent of patient education activities, 75 percent of the outpatient and emergency service activities, and 70 percent of the inpatient or hospice care activities were on or ahead of schedule. Two-thirds of the swing bed conversion programs were also on or ahead of schedule.

Activities more likely to be behind schedule are those that the hospitals are unlikely to have complete control over. Thirty-seven percent of the hospitals establishing a rural health network were behind schedule, slightly higher than the proportion (36 percent)

TABLE IV.1
DISTRIBUTION OF PROJECT TIMELINESS BY PROJECT OBJECTIVE
AND WHO DIRECTS PROJECT: 1990 GRANTEES¹

Characteristic	Total	Ahead of Schedule	On Schedule	Behind Schedule by More than One Month	Completed
Project Objective					
Planning or Market Analysis	114	2%	40%	28%	31%
Construction or Renovation	66	3%	44%	36%	17%
Equipment Purchase	138	1%	51%	21%	27%
Recruiting	158	1%	37%	32%	30%
Training or Staff Development	105	0%	63%	22%	15%
Education, Prevention, or Wellness Programs	85	7%	78%	13%	2%
Inpatient or Hospice Service	20	5%	65%	15%	15%
Outpatient Service	57	5%	72%	19%	4%
Clinic	40	13%	43%	40%	5%
Emergency Medical Services	20	0%	75%	15%	10%
Swing Beds	9	0%	67%	0%	33%
Other Health Service	16	13%	44%	38%	6%
Rural Health Network	71	0%	52%	37%	11%
Other	26	15%	62%	23%	0%
Who Directs Project?					
Hospital Administrator	114	1%	39%	60%	0%
Another Staff Member or Outside Consultant	61	7%	34%	59%	0%
Multiple Project Directors	13	0%	15%	85%	0%
Total	188	3%	36%	61%	0%

NOTE: Totals may not add to 100 percent due to rounding error.

¹Project timeliness is defined by the project's most delayed activity. For example, a project that is on schedule in only one activity and ahead of schedule on all the rest is defined here to be on schedule.

behind schedule with construction or renovation projects. About a third (32 percent) of the hospitals recruiting personnel were also behind schedule. In addition, 40 percent of the projects establishing clinics or other types of health services were at least a month behind schedule.

Of the 188 projects, 114 (61 percent) are directed by the hospital administrator; another 61 projects (32 percent) are led by an outside consultant or a hospital staff member. Only 7 percent of the projects had multiple directors. The project leadership is very similar to the 1989 Rural Health Care Transition projects where 58 percent of the projects were directed by the hospital administrator, 39 percent by an outside consultant or a hospital staff members, and 4 percent by multiple directors.

Project leadership seems to have a slight effect on progress. Although the magnitude is small, projects led by a hospital staff member or an outside consultant are more likely to be ahead of schedule than were the projects under other leadership. However, they were just as likely to be behind schedule as were those directed by the hospital administrator. Projects with multiple directors are most likely to be behind schedule. The relationship between project leadership and timeliness after 6 months is consistent between the 1989 and the 1990 grantees, with the exception of projects led by multiple directors. Among the 1989 grantees, projects led by multiple project directors were least likely to be behind schedule.

2. Operational Successes and Difficulties

Successes. Among the reasons frequently cited for project success were:

- The development of a viable strategic plan (cited by 69 percent of the hospitals)

- The ability to coordinate services and to work with other organizations (cited by 66 percent)
- The ability to recruit and/or retain personnel (cited by 65 percent)
- The availability of funds (cited by 59 percent)

Often times, hospitals that attributed their success to their strategic plan used the planning process to mobilize support for the project. One hospital won physician support for outpatient services during the planning stage; another indicated that the planning process reassured other participants about the feasibility of the project. Hospitals also cited the importance of having an open planning process in which suggestions from staff and the community were sought, and hospitals were receptive to the suggestions received.

An attitude of cooperation among community organizations and other health care providers appears to have been facilitated by the recognition that they were each facing the same problems. One hospital credits the consortium approach for making the hospitals conscious of this fact. Another hospital noted that, by working in groups, hospitals could address problems that they could not on their own.

Some hospitals reported that the relationships they developed with outside organizations enabled them to access critical resources. For example, the University of Texas Health Science Center provided one of the rural hospitals with the structure, credibility, and medical expertise necessary to achieve its project goals. All of the hospitals participating in a consortium emphasized the advantages of having other organizations and individuals involved in the project.

Many of the hospitals indicated that the Rural Health Care Transition grant played a significant role in the success of their projects, making it financially feasible for some

hospitals to undertake projects that they may not have been able to do otherwise and making it possible for others to develop better programs.

However, the grant's impact was not only felt financially. One hospital reported that winning the grant boosted staff morale and helped to convince the Board and the community to make needed changes. Other hospitals indicated that the grant opened doors to other resources that would have otherwise remained closed.

Another frequently cited success was recruiting and retaining personnel. The successful recruitment of medical staff is no small accomplishment given the small pool of health professionals who are attracted to rural practice and life. Some hospitals undertook special efforts to recruit physicians. In one case, the hospitals sent a member of its medical staff to visit the candidates. Another hospital enlisted the support of its Board of Directors, the community, and a consultant in its recruitment efforts. The successful recruitment of a single physician at a small hospital can have a tremendous effect on its circumstances. One hospital reported that the addition of an orthopedist increased the census and revenues in every one of its departments beyond anyone's expectation.

Difficulties. The most frequently mentioned difficulties were:

- Recruitment and/or retention of personnel (cited by 40 percent of the hospitals)
- Cross-organizational coordination (cited by 27 percent)

The hospitals offered many explanations for their recruitment and retention difficulties. Among these explanations were the hospital's inability to offer competitive

salaries or purchase the equipment need by the physician, and a shortage of health professionals in the area or who are willing to relocate to and live in rural areas.

Similarly, there were many explanations for having cross-organizational difficulties. Competition for patients seems to be one of the sources. One hospital's effort to establish a new low-cost primary care service was met with resistance by other providers in the area who were concerned about losing their market share. Another reason cited for coordination difficulties was having a closed planning process. For example, one hospital used a small group of motivated people to draw up a plan; however, the plan was not readily accepted by the hospital and community at large.

B. PROJECT MODIFICATIONS

During the first 6 months, none of the hospitals significantly changed their project scope. A few hospitals anticipate making project modifications, but thus far none have made significant changes.

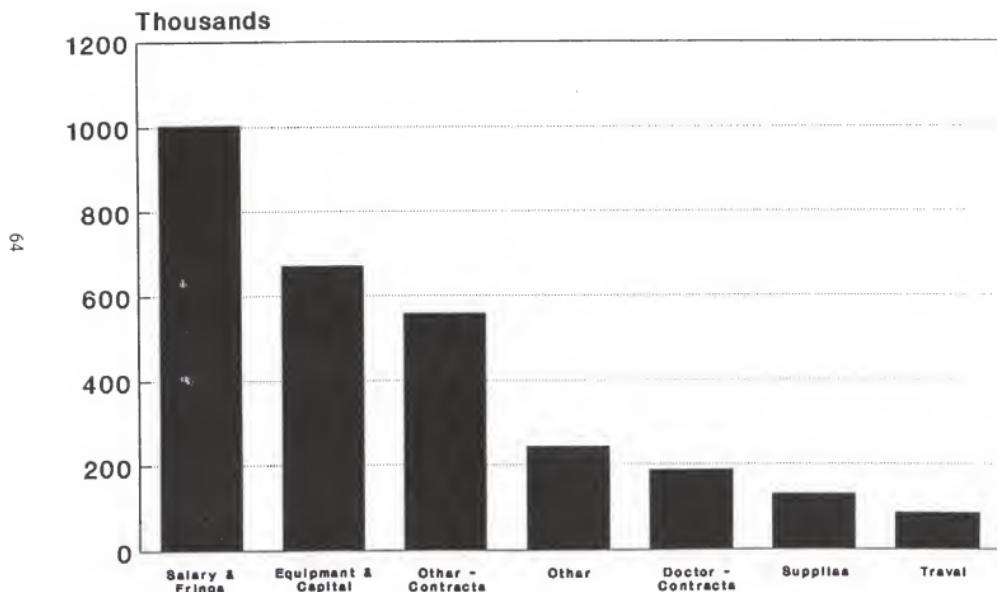
C. EXPENDITURES

A total of \$9,372,983 was awarded to the 211 hospitals receiving new Rural Health Care Transition grants in 1990. With the voluntary withdrawal of two of the hospitals, the total obligated amount for the first year decreased to \$9,273,003. During the first 6 months, the 187 reporting hospitals (188 grants) spent \$2,879,073; an average of \$15,314 per grant.

As Figure IV.1 shows, most of the grant project expenditures fell into three categories:

- Salary and fringe: \$1,003,724 (35 percent)

FIGURE IV.1
Total Expenditures After 6 Months
by Category: 1990 Grantees



- Equipment and capital: \$670,321 (23 percent)
- Nonphysician contracts: \$558,004 (19 percent)

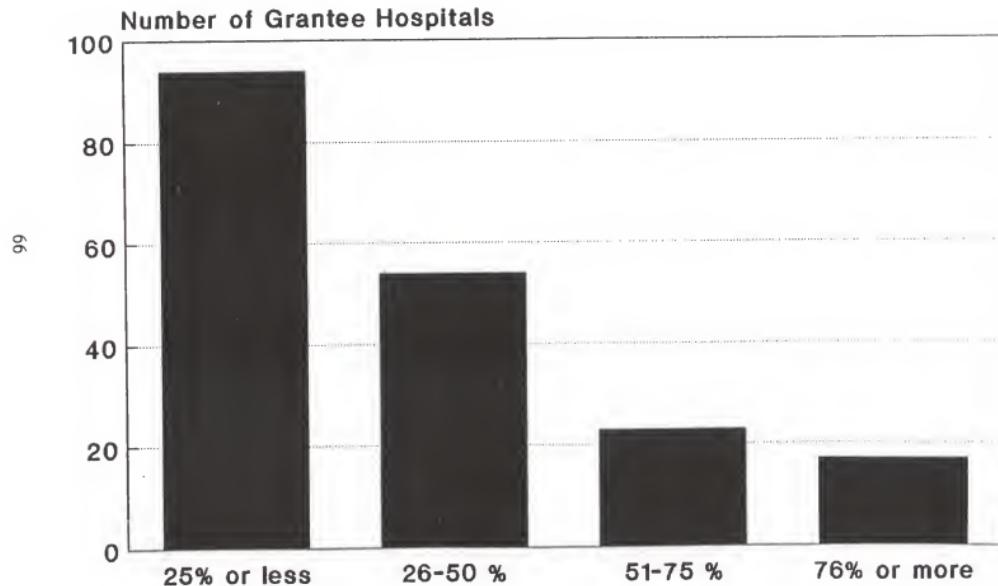
These figures are quite similar to those reported by the 1989 grantees 6 months into their grant projects. The 1989 grantees reported spending 37 percent of their first 6 month's expenditures on salary and fringe and 29 percent on capital and equipment. The 1989 grantees reported spending only 16 percent for contracts (including physician and nonphysician service contracts), 10 percent less than the 1990 grantees spent towards physician and nonphysician contracts.

As might be expected, project objectives influenced the use of funds. Projects with recruitment objectives have higher salary expenses. Hospitals with hospital staff training as an objective also reported higher salary expenses. The funds for salary were apparently used to staff patient education programs and new inpatient, outpatient, and, to a lesser extent, clinic services, since projects with these objectives also reported higher salary expenses.

Capital expenses, not surprisingly, were higher among the hospitals that were planning to purchase equipment; in particular, those for transportation and laboratory or treatment, or to renovate or convert parts of the hospital. It should be noted that hospitals whose project called for new construction were more likely not to have spent any of the first year funds during the first 6 months.

Figure IV.2 shows the distribution of hospitals in terms of the proportion of the first year grant funds spent. Only 16 of the 187 reporting hospitals (9 percent) spent more than 75 percent of the first year grant fund. Another 21 hospitals (11 percent) have

FIGURE IV.2
Percentage of First Year Funding Spent
After 6 Months: 1990 Grantees



spent more than half of their first year funds. In contrast, 95 hospitals (51 percent) have spent 25 percent or less of their award. The remaining 55 hospitals (29 percent) have spent between a quarter and a half of the grant award.

As one might expect, hospitals spending a smaller proportion of their first year grant award were the ones most likely to be behind schedule (See Table IV.2). Of the hospitals spending 25 percent or less of their first year grant award, 69 percent are at least a month behind schedule. In contrast, among the hospitals that spent more than 75 percent of their first year grant award in the first 6 months, 38 percent were behind schedule.

TABLE IV.2

PERCENTAGE OF GRANT FUNDS SPENT BY PROJECT TIMELINESS: 1990 GRANTEES¹

Percent of First Year Grant Funds Spent After Six Months	Total Number	Ahead of Schedule	On Schedule	Behind Schedule by More Than One Month	Completed
25 percent or less	96	1%	30%	69%	0%
26 - 50 percent	55	7%	33%	60%	0%
51 - 75 percent	21	0%	52%	48%	0%
Greater than 75 percent	16	0%	63%	38%	0%
TOTAL	188	3%	36%	61%	0%

NOTE: Totals may not add to 100 percent due to rounding error.

¹Project timeliness is defined by the project's most delayed activity. For example, a project that is on schedule in only one activity and ahead of schedule on all the rest is defined here to be on schedule.

V. SUMMARY OF HOSPITAL PROGRESS FOR 1989 AND 1990 GRANTEES

Eighteen months after the first 181 hospitals were awarded Rural Health Care Transition Grants, 169 of them are actively pursuing their projects. Five hospitals have completed their projects (one of which continues with a second grant project), four have voluntarily discontinued their grants, three have ceased operations as acute care institutions, and one grant was discontinued by HCFA. On September 15, 1990, 212 additional awards were made to 211 hospitals. Six months later, 209 hospitals are actively pursuing their projects. Two hospitals voluntarily discontinued their grant projects. Thus, as of March 30, 1991, 378 hospitals are still working towards their project goals.

Based upon the self-reported data, the grantees appear to be making steady progress. A larger percentage of the 1989 grantees have fallen behind schedule relative to their progress 6 months ago, but those with construction and renovation activities and swing bed conversions have also completed a fair proportion of their activities. The 1989 consortia projects are making solid progress and are more likely to be on schedule compared to the individual hospital projects. The 1990 grantees have had a slow start, but substantial progress has been made on strategic planning and outpatient service development.

The primary reasons for the successful implementation of the 1989 grantees' projects and the successful startups of the 1990 grantees' projects are the availability of funds, cross-organizational support and successful recruitment of health care personnel. The 1989 grantees also attribute success after 18 months to their projects filling a demand for health

care services in the community. The 1990 grantees also cite strong strategic planning as a primary reason for their successful startup.

The 1989 grantees have spent the majority of the funds that they were awarded. A few hospitals that have delayed the implementation of their projects have spent only a small part of their grants, but the majority have spent over 50 percent. The 1990 grantees have spent less than half of their first year allotment; this is similar to the rate of spending by the 1989 grantees after 6 months. Both the 1989 and 1990 grantees have spent their grants primarily on personnel, contracts, and capital equipments, with limited amounts spent on supplies and travel.

It is still too early to tell definitely how the grant program affects access to care. However, on average the number of health care professionals has increased among the 1989 grantees, suggesting that access to health care professionals may be improving. Numerous services have been added by the 1989 grantees--including outpatient specialty clinics, diagnostic imaging services, cardiac rehabilitation, and occupational-therapy, all of which improve access by reducing travel time for patients using them, as well as home health services, which provide services at home which patients previously had to manage without. Although seven of 181 1989 grantee hospitals have closed, four of them used their grants to plan their transition from an acute care institution to another type of health care provider, including primary care clinic services. Whether these changes will actually increase the long run viability of the health care institutions, and in turn affect access to health care in the long run, is still unknown.

VI. ACTIVITIES FOR THE NEXT 6 MONTHS

A. MONITORING

As the 1989 and 1990 grantees complete, respectively, the second and first year of their projects, we will continue to monitor their progress through semi-annual reports, telephone follow-up, and site visits. The next semi-annual report is due in October 1991, covering the period March 31 to September 30, 1991.

B. SITE VISITS

In the next several weeks, we will select sites that will be visited during 1991. These visits include revisits to five 1989 grantees already visited in 1989 or 1990. The grant projects to be revisited will be those that appear to be most effective in stabilizing the hospitals' managerial and financial status. Ten new sites will be selected from among the 1989 grantees. These will be selected to provide wide geographic distribution, varying hospital size, and varied project objectives. In addition, 10 1990 grantees will be selected to be visited three times over the 3 project years. The criteria for selecting the 1990 hospitals stress the type, length, and costliness of the project. Thus, a total of 25 grantees will be visited in 1991. Telephone interviews will also be conducted with hospital staff from the 15 1989 grantee hospitals not selected for revisiting.

C. REPORTS

The fifth report on the grant program will describe the progress of both 1989 and 1990 grantees from March 31 to September 30, 1991, based on hospital self-reports.

Special topics to be covered in the fifth report include detailed background characteristics of the 1990 grantees, financial status of 1989 and 1990 grantees, and a detailed discussion of project progress based on the case studies of 35 hospitals visited or followed up by telephone during 1991.

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